SECTION 1915(c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b._X_ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b._X_ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a._X_ Nursing facility (NF)

   b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.____ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ aged (age 65 and older)

b. X disabled

c.____ aged and disabled

d.____ mentally retarded

e.____ developmentally disabled

f.____ mentally retarded and developmentally disabled

g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. X Waiver services are limited to the following age groups (specify):

Age 18 and above

b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

This waiver specifically provides services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60. The disease(s) or condition(s) are: quadraplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophies, spinal muscular atrophy, severe cerebral palsy, stroke, and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehon Syndrome.

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.____ Other criteria. (Specify):

e.____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of

this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of ə1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.____ No c.__X__ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.__X__ Yes b.____ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.____ Yes b.__X__ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.__X__ Case management

b.____ Homemaker

c.____ Home health aide services

d.__X__ Personal care services

e.____ Respite care

f.____ Adult day health

g.____ Habilitation

____ Residential habilitation

____ Day habilitation

____ Prevocational services

____ Supported employment services

____ Educational services

h._X_ Environmental accessibility adaptations

i.____ Skilled nursing

j.____ Transportation

k.____ Specialized medical equipment and supplies

l.____ Chore services

m._X_ Personal Emergency Response Systems

n.____ Companion services

o.____ Private duty nursing

p.____ Family training

q.____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s.____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

t. X Other services (specify):

Assistive Technology, Minor Assistive Technology, Medical Supplies, Evaluations for Assistive Technology, Assistive Technology Repairs and Personal Assistance Services

u.___ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid Agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. N/A When provided as part of respite care in a facility approved by the State that is not a

private residence (hospital, NF, foster home, or community residential facility).

b. N/A Meals furnished as part of a program of adult day health services.

c. N/A When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid Agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ____ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of April 1, 2005 is requested.

20. The State contact person for this request is Latonda Cunningham, who can be reached by telephone at (334) 353-4122.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:
Print Name:
Title:
Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__X__The waiver will be operated by Department of Rehabilitation Services, a separate agency of the State, under the supervision of the Medicaid Agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

_____The waiver will be operated by _____ , a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined

herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _X_ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

_X_ Other Service Definition (Specify):

Please See Attached Scope of Service Definition

b._X_ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

___ Personal care providers may be members of the

individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

A licensed practical nurse, licensed to practice nursing in the State.

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_X_ Other service definition (Specify):

Please See Scope of Service Definitions

c._X_ Environmental accessibility adaptations:

_X_ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_X_ Other service definition (Specify):

Please See the Attached Scope of Service

d._X_ Personal Emergency Response Systems (PERS)

___ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help"

button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_X_ Other service definition (Specify):

Please See the Attached Scope of Service Definition

e._X_ Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Medical Supplies, Minor Assistive Technology, Assistive Technology, Evaluation for Assistive Technology, Assistive Technology Repair and Personal Assistance Services.

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Case Management				See Minimum Qualifications in Attached Scope of Services
Personal Care				See Minimum Qualifications in Attached Scope of Services
Environmental Accessibility Adaptations				See Minimum Qualifications in Attached Scope of Services
Medical Supplies				See Minimum Qualifications in Attached Scope of Services
Minor Assistive Technology				See Minimum Qualifications in Attached Scope of Services
Assistive Technology				See Minimum Qualifications in Attached Scope of Services

Evaluations for Assistive Technology				See Minimum Qualifications in Attached Scope of Services
Assistive Technology Repairs				See Minimum Qualifications in Attached Scope of Services
Personal Emergency Response System				See Minimum Qualifications in Attached Scope of Services
Personal Assistance Services				See Minimum Qualifications in Attached Scope of Services

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

N/A

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_X_ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

___ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid Agency.

SCOPE OF SERVICE DEFINITIONS
FOR THE
STATE OF ALABAMA INDEPENDENT LIVING WAIVER (SAIL)

CASE MANAGEMENT SERVICES
SAIL WAIVER

Case Management Services will assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services.

Case management activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain a person in the community.

Case managers shall be responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care.

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of the Plan of Care as specified in the waiver document.

A. Objective

The objective of case management is to assist clients with making and managing their decisions regarding long term care. It also ensures continued access to appropriate, available and desired services by the client.

Medicaid will not reimburse for activities performed which are not within the Scope of Services.

B. Description of Service

1. The unit of service will be per 15 minute increments commencing on the date that the client is determined eligible for the State of Alabama Independent Living (SAIL) Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required monthly in addition to any other case management activities.

   A unit of service for Case Management that assists in the transitioning of individuals from institutional settings into the community will be per 15 minute increments beginning on the first date the case manager goes to the institution to complete an initial assessment. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor.

2. Services may or may not be provided on those weekends and/or days designated as Alabama State legal holidays. Case managers have 13 paid holidays annually. They may elect to request approval from the State Coordinator to work on a holiday or weekend, i.e., personal illness, illness of a family members, personal problems, etc., that will prevent them from doing their monthly face-to-face visit.

3. The intensity of case management services provided to each client is dependent upon the individual client's needs, as set forth in the Plan of Care which is developed by the case managers in conjunction with the client, primary caregiver, and/or family member. At least one face to face visit is required monthly in addition to any other case management activities.

4. Case management includes the following activities: initial assessment; developing, monitoring and evaluating the Plan of Care; authorizations for waiver services (including transitional, initial, changed, interrupted, redetermination and terminated authorizations); referrals to other agencies as needed; service coordination; case monitoring, monthly or more often as appropriate; review and initial the plan of care every 60 days with the client, responsible party, and/or knowledgeable other; re-evaluation; level of care at redetermination; case termination and transfer; and establish and maintain client case record.

5. All SAIL Waiver recipients will receive Case Management Services.

6. Case Management is a waiver service and must be on the Plan of Care. Waiver services not listed on the Plan of Care and the Service Authorization Form will not be paid.

C. Intake Screening

1. Prior to waiver assessment, all potential clients are screened to determine their eligibility and desire for waiver participation. These activities are distinct from case management but are included in this Scope of Service since they are preliminary activities necessary for waiver enrollment. With the exception of case management activities for individuals transitioning from an institution into the community, case management activities provided to a client prior to waiver approval are considered administrative.

2. Intake screening activities will be conducted by case managers.

3. Case management can be provided to individuals transitioning from an institution to the community for up to 180 days prior to discharge. When this service is provided to transition clients, assistance will be exercised in facilitating and coordinating community-based services from institutional settings. Referrals may be received from but not limited

to:

- Client
- Family members
- Nursing facility staff
- Physician

The following tools will be provided by the operating agency for use by case managers assisting in the transition of individuals from institutions into the community:

- An interview tool for residents interested in transition to assess preferences, service support needs and available community resources;
- An overview and explanation of the person-centered planning process;
- A timeline of recommended activities for the case manager to consider before the individual transitions from the institution and during the first month after the individual leaves the institution.

*If the person is not eventually served in the community due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc, the case management activities may be billed as Administrative Case Management.

Case Management service includes the following activities:

a. Assessment - a method of determining a client's current long term care needs through the use of a comprehensive assessment instrument. The assessment instrument is utilized to assess each individual client's functional, medical, social, environmental, and behavioral status. Information obtained during the assessment process should be adequate to make a level of care decision and for case managers to gather information for an initial Plan of Care.

b. Level of Care Determination - the process of identifying the extent of a person's medical and functional disability in keeping with the Alabama Medicaid Agency Level of Care criteria. By applying these criteria, a client's level of care can be determined.

For residents in the nursing facility interested in transitioning into the community, the case manager should thoroughly review referrals and intake information. This process will take place during the 180 consecutive days transition period. An initial face-to-face introductory interview to discern each resident's interest in leaving the nursing facility will be performed.

A visit can be made to discuss the overall medical and physical condition of the resident and also evaluate all community resources available to meet the resident's needs. This meeting will also include the resident, family or sponsors to assist in

developing a Transitional Plan of Care for the move to the community.

A visit is made to finalize the Transitional Plan of Care and to assure all involved are aware of the services available to maintain the client in the community.

Following referral and intake, the case manager makes a face-to-face visit with the client for evaluation and completion of the assessment form. To clarify the assessment information, the case manager may consult with the client and/or family, and physician, with regard to medical, behavioral , functional and social information.

Once the Case Manager has adequate information for a sound level of care determination an initial Plan of Care is completed. The complete application packet is submitted to the Alabama Medicaid Agency. The assessment information is evaluated by a RN and a level of care determination is made in accordance with the Level of Care Criteria for Alabama Medicaid Agency Long Term Care Services. If the RN is unable to make a level of care decision, a referral must be made to the Medicaid staff physician. Justification for level of care determination must be properly documented.

c. Choice of Institution or Community Care - Initially, each client must make a written choice between institutional or community care, which will remain in effect until such time as the client changes his/her choice of service location. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, certification and/or services should not be denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice should be carefully documented. A responsible party should be encouraged to work with the case manager in developing an appropriate Plan of Care.

When a capable client is presented with realistic options and ultimately chooses community placement or institutional placement, the case manager should support that decision. However, when the client's choice is not realistic and the choice puts the client in an unsafe situation, the case manager should point out to the client that the choice is not in keeping with his/her service needs. Once this has been done, the service choice is still the client's decision. It is important to document this discussion and continue to work with the client toward the safest possible Plan of Care.

For transitioning clients, the case manager should obtain from page 3 of the HCBS-1 application the Certificate of Choice Statement signed by the client indicating the individual's desire to transition into a community setting.

d. Eligibility Determination

1. Verifying client's financial eligibility is an important function of the case manager. If a client is seeking waiver services, but is not currently SSI eligible and it appears that he/she may qualify, he/she should be referred to the local social security office, unless a recent application has been made. If a client is not SSI eligible due to excess income of client, parent(s) or spouse, a financial application (Form 204) must be submitted along with the waiver application form. The case manager should always inform the client/family of the application process. Medicaid (financial) eligibility must be verified monthly.

2. Financial eligibility should be established as soon as practical for individuals transitioning from an institution to the community.

3. Applicants must reside in a nursing facility for at least 90 days before the individual will be considered a candidate for transition.

4. A community doctor must provide a statement that the client can be maintained in a community setting/least restrictive setting. Prior to the transition of the individual from the institution, a final team meeting should be scheduled to ensure coordination of all transition activities.

e. Developing a Plan of Care for Case Management and Transitional Case Management - both include a comprehensive review of the client's problems and strengths. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development should include participation by the client and/or family/primary caregiver, and case manager. The Plan of Care development process provides involved persons with the information necessary to make an informed choice regarding the location of care and services to be utilized.

Development of the Plan of Care for all individuals transitioning from the institution is based on individual needs. Development of the Plan of Care should include participation by the individual's family/sponsor and case manager. This process will provide information for all individuals to make informed choices regarding available community services and support. During the transition period, special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the client to make sure services are appropriate for client's needs.

Transitional Case Management also includes the development of a realistic and thorough Plan of Care and its implementation in the community involves numerous contacts and extensive planning and coordination.

The Plan of Care development must include exploration of the resources currently utilized by the client, both formal and informal, as well as those additional services which may be available to meet the client's needs. Service planning includes a visit with the client and contact with the family members and/or existing potential community resources.

f. Service Coordination - will be accomplished by the case manager along with input from the client/family/caregiver, and other involved agencies/parties as needed. All services needed by the client will be included in the Plan of Care implemented by the case manager.

Through careful monitoring, needed changes in the existing services shall be promptly identified. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service contracts will be updated to reflect any changes in service needs.

g. Monitoring - each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed. The Plan of Care must be reviewed every 60 days in the presence of the client to make sure services are appropriate for client's needs.

Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

Clients and/or responsible relatives shall be instructed to notify the case manager if services are not initiated as planned, or if the client's condition changes. However, it is the responsibility of the case manager to promptly identify and implement needed changes in the Plan of Care .

h. Re-determination - A complete review of every case will be done at least annually. The review shall include completion of the same comprehensive standard assessment used in the initial assessment. The client's choice of location will be verified, Medicaid eligibility verified, and a new Plan of Care developed by the case manager.

It may be necessary due to reported or observed changes in a client's condition to update the assessment as needed but at least annually. This shall be done by completing a new assessment form. An update shall always be accompanied by a

reevaluation of the client's level of care and service needs. The Plan of Care will be revised as necessary.

i. Plan of Care - After the Plan of Care is completed and implemented; it will be evaluated for its effectiveness. The time frame for this evaluation will depend on numerous factors and will vary, but will always be completed at least annually corresponding with the client's waiver eligibility dates.
An evaluation of the Plan of Care includes a review of the previously set goals to determine if they have been met. This evaluation shall take place at the end of the time frame set for the goal to be achieved. The family, providers and caregivers may be contacted for their input in evaluating the effectiveness of the Plan of Care and any changes that have occurred in the client's condition or support system.

The Plan of Care must be reviewed and initialed every sixty (60) days by the case manager. During the 60-day review, the case manager will review the Plan of Care with the client, responsible party, and/or knowledgeable other. Additions, deletions, or other changes are written in by the case manager, to be later updated. A copy of the Plan of Care remains in the client's home.

j. Initial Contract of Waiver Services - waivered services will be based on a client's need as documented in the Plan of Care. The plan of care should be a clear, factual representation of the client's need and support the rationale and appropriateness for a service contract.

The case manager will issue a written service contract to a provider to initiate a waivered service. The contract should be specific and accurate including the number of units per visit and number of days per week, which services are to be provided.

The amount, frequency and duration of a service depend on the client's needs, but may not exceed the statewide average cost for the same level of care in a nursing home. In some cases, a client may require services, which exceed the statewide average cost of institutional care. These cases should be monitored closely to ensure community services are appropriate and that client's health and safety are protected.

k. Changes in Services within Contract Period - Services may be initiated or changed at any time within a contract period to accommodate a client's changing needs. Any change in waivered services necessitates a revision of the Plan of Care. The

revised Plan of Care must coincide with the narrative explaining the change and a new Service Contract Form should be submitted by the Case Manager.

l. Termination of Waivered Services - Any time a client no longer requires a service, the service must be officially terminated. Advance notice and appeal rights regarding the reduction, suspension or termination of a waiver service must be granted to the client. Waivered services may be terminated at any time during the contract period. Termination of a service will necessitate a revision of the Plan of Care. A Service Authorization Form indicating the service is terminated must be forwarded to each DSP.

m. Case Termination and Transfer - When an applicant or a current waiver client relocates to another county, the case is transferred to the receiving case manager. The transferring case manager prepares all necessary materials and makes initial contact with the receiving case manager. The receiving case manager is responsible for coordinating the continuation of the client's waiver services.

Termination involves all activities associated with closing a waiver case when a client exits the program for specified reasons. When a client is to be terminated from the Waiver Program, all service providers should be notified of the client's discharge in a timely manner. At the point of termination, the case manager should assist as much as possible in making alternative arrangements in meeting the client's needs.

n. Maintaining and Documenting Case Record - Adequate documentation is one of the most important tools in determining the success of the waiver program. It is vital to maintain documentation on all aspects of the waiver: from the initial data gathering process, delivery of services, complaints and grievances from recipients and providers, billing and payment records, levels of care, plans of care, case management narrative and cost effectiveness data. This information is used to assure that the State is operating the waiver in accordance with the approved waiver document and that waiver services are appropriate for the individuals being served.

D. Case Management Qualifications

1. Routine, ongoing, case management services will be conducted by case managers who meet minimum qualifications below:

a. Professionals having earned a Master of Arts degree or a Master of Science degree, preferably in Rehabilitation Counseling or related field, from an accredited college or university, or having earned a degree from an accredited School of Nursing. Transitional Case Management Services may be delivered by a SAIL employee

possessing a BS degree in social work, psychology or related field who has provided services as an Independent Living Specialist.

b. Transitional Case Management Services will also be conducted by case managers

who meet the minimum accredited college/university qualifications described above.

c. Demonstrate capacity to provide all core elements of case management:

(1) assessment,
(2) Plan of Care development,
(3) linking/coordination of services,
(4) monitoring,
(5) reassessment/follow-up, and
(6) documentation.

d. Demonstrate case management experience in coordinating and linking such community resources as required by the SAIL Waiver target population.

e. Demonstrate experience with the waiver target population.

f. Capacity to document and maintain individual case records in accordance with state and
federal requirements.

g. Demonstrate ability to assure a referral process consistent with Section 1902a (23) the Social Security Act, freedom of choice of provider.

2. All case managers will be required to attend a Case Managers' Orientation Program provided by the operating agency and approved by the Alabama Medicaid Agency and attends on-going training and in-service programs deemed appropriate.

a. Initial orientation and training must be completed within the first three (3) months of case manager employment. Any exception to this requirement must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the case manager's personnel file.

b. The operating agency will be responsible for providing a minimum of six (6) hours relevant in-service training per calendar year for case managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year. Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location and outcome of training. Topics for specific in-service training may be mandated by the Alabama Medicaid Agency. Annual in-

service training is in addition to the required orientation and training discussed in item 2a. Proof of training must be recorded in the personnel file. The operating agency shall submit proposed programs to Medicaid at least forty-five (45) days

prior to the planned implementation. Any exception must be approved by the Alabama Medicaid Agency.

3. The operating agency must have a Quality Assurance Program for case management services in place and approved by the Alabama Medicaid Agency. The Quality Assurance program shall include case manager record reviews at a minimum of every ninety (90) days. Documentation of quality assurance reviews and corrective action must be maintained by the operating agency and will be subject to review by the Alabama Medicaid Agency.

4. Documentation and Record-keeping

The operating agency shall maintain a record-keeping system that documents the units of case management service delivered. Case management documentation shall be made available upon request to Medicaid, or other agencies as designated in the contractual agreement.

The operating agency shall maintain a file on each case manager, which shall include the following:

1. Each employee's application for employment
2. Job description
3. Record of pre-employment and in-service training
4. Initial orientation/training and annual in-service
5. Evaluations
6. Supervisory visits and case management quality assurance reports
7. Work attendance
8. Reference contacts.

The operating agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

5. Rights , Responsibilities and Service Complaints

1. The operating agency has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The operating agency will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will

provide information about how to register a complaint with the case manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against a case manager will be investigated by the operating agency and documented in the client's file.

b. The case manager supervisor will contact the case manager by letter or telephone about any complaint against the case manager and any recommended corrective action.

c. The case manager supervisor will take the necessary action and document the action taken in the client's and employee's files.

d. All other complaints to be investigated will be referred to the case manager who will take appropriate action.

e. Complaints from individuals transitioning from the institution will be referred to the case manager who will take the appropriate action to resolve the complaint.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

6. Policy and Procedures Manual

In addition to the foregoing, providers of case management services will adhere to the current SAIL Policy and Procedures Manual and all subsequent revisions.

F. Administrative Requirements

1. The operating agency shall designate an individual to serve as the waiver coordinator who will ensure that only qualified employee personnel are employed and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated coordinator will have the authority and responsibility for the direction of the waiver service program for the operating agency. The operating agency, in writing, shall notify the Alabama Medicaid Agency within three (3) working days in the event of a change in the coordinator, address, telephone number, or of an extended absence of the coordinator.

2. The operating agency will maintain an organizational chart indicating the line of authority and responsibility, and make it available to the Alabama Medicaid Agency upon request.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. The operating agency will maintain a policy and procedures manual to describe how activities will be performed in accordance with the terms of this contract and include the organization's emergency plan. The Alabama Medicaid Agency must approve all policies

and procedures.

PERSONAL CARE SERVICES
SAIL WAIVER

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

Personal care must be provided by an individual that is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

A. Objectives

The objective of the Personal Care (PC) Service is to maintain and promote the health status of clients through home support, health monitoring, support and assistance with activities of daily living.

Medicaid will not reimburse for activities performed which are not within the scope of services.

B. Provider Experience

Agencies desiring to be a provider of PC services must have demonstrated experience in providing PC or a similar service to the Operating Agency (OA).

C. Description of Services to be Provided

1. The Unit of Service will be per 15 minute increments of direct PC service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Provider Contract. The amount of time authorized does not include provider transportation time to and from the client's residence.

2. The Direct Service Provider (DSP) shall provide its regular scheduled holidays to the Operating Agency (OA), and the DSP shall not be required to furnish services on those days. The DSP agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation.

3. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the case manager.

4. PC services include:

a. Support for activities of daily living, e.g., provided to the recipient and not family members:
-bathing
-personal grooming
-personal hygiene
-meal planning and preparation
-assisting clients in and out of bed
-assisting with ambulation

b. Home Support that is essential to the health and welfare of the recipient, e.g.
-light cleaning
-light laundry
-home safety

c. Basic monitoring of the client, such as skin condition while bathing, excessive sweating, abnormal breathing, abnormal lethargy, and recognition of emergencies.

d. Medication monitoring, e.g., the type that would consist of informing the client that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the PCW is responsible for giving the medicine; however, it does not preclude the PCW from handing the medicine container to the client.

e. Under no circumstance should any type of skilled medical service be performed by the PCW.

f. Personal Care services are not an entitlement. It is based on the needs of the individual client.

D. Staffing

The DSP must provide all of the following and may make subcontractual arrangements for some but not all of the following:

1. A registered nurse(s) who meets the following requirements:

a. Currently licensed by the Alabama State Board of Nursing to practice nursing.

b. Must pass a statewide and local background check.

c. At least two (2) years experience as a registered nurse in public health, hospital or long term care nursing.

d. Make the initial visit to the client's residence prior to the start of PC services for the purpose of reviewing the Plan of Care and giving the client written information regarding advance directives.

e. Current verification of an annual TB Skin Test must be in the employee's personnel record.

2. A licensed practical nurse(s) who meets the following requirements:

a. Currently licensed by the Alabama State Board of Nursing to practice nursing.

b. At least two (2) years experience as a licensed practical nurse in public health, hospital or long term care nursing.

c. Must pass a local and statewide background check.

d. Capable of evaluating the PCW in terms of his or her ability to carry out assigned duties and his/her ability to relate to the client.

e . Ability to assume responsibility for in-service training for PCWs by individual instruction, group meetings or workshops.

f. Current verification of an annual TB Skin Test must be in the employee's personnel record.

3. PCWs who meet the following qualifications and requirements:

a. Must have references which will be verified thoroughly.

b. Must pass a local and statewide background check.

c. Must be able to read and write.

d. Must have at least completed eighth grade.

e. Must be able to follow the Plan of Care with minimal supervision unless there is

a change in the client's condition.

f. Must have no physical/mental impairment to prevent lifting, transferring, or providing any other assistance to the client.

g. Must assist client appropriately with daily living activities related to personal care.

h. Current verification of an annual TB Skin Test must be in the employee's personnel record.

i. Must complete a probationary period determined by the employer with continued employment contingent on completion of personal care in-service training program and client's satisfaction.

j. Must be employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

k. Personal care services provided by family members or friends may be covered only if the family members or friends meet qualifications for providers of care; there are strict controls to assure that payment is made to the relative or friends as providers only in return for personal care services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The case manager must have documentation in the client's file showing that attempts were made to secure other qualified providers before a family member or friend is considered. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent. The OA is responsible for reviewing these records and verifying there is proper supportive documentation to the lack of qualified providers living in a remote area.

l. Personal Choices participants (Cash and Counseling Pilot Project) may hire legally liable relatives, as paid providers of the personal care services. However, restrictions do apply on participant living arrangements, when homes or property are owned, operated or controlled by a provider of services, not related by blood or marriage to the participant. (refer to: AL SPA 07-002; Attachment 3.1-A 1915 (J) vi.)

4. Nursing Supervision:

PC services must be provided under the supervision of the licensed practical nurse who meets the requirements of D. 1. a. - d. and will:

a. Make visits to the client's residence after the initial visit by the registered nurse.

b. Be immediately accessible by phone and must be physically accessible within (60) minutes from the client's residence during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours if this position ceases to be filled.

c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.

d. Provide on-site (clients' place of residence) supervision of the PCW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW.

e. Observe each PCW with at least one (l) assigned client at a minimum of every six (6) months or more frequently if warranted by substandard performance of the PCW. This function may be carried out in conjunction with one of the 60-day supervisory visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file.

f. Assist PCWs as necessary as they provide individual personal care services as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

5. The following are the minimum training requirements for PCWs. The minimum

training requirement must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training.

a. Personal care training program should stress the physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, and his/her property.

NOTE: The PC training program must be approved by the OA.

Minimum training requirements must include the following areas:

-Activities of daily living, e.g.,

. bathing (sponge, tub)
. personal grooming
. personal hygiene (client and Personal Care Worker)
. meal planning and preparation
. proper transfer technique (assisting clients in and out of bed)
. assistance with ambulation
. proper lifting techniques

- Home support, e.g.,

. light cleaning
. light laundry
. home safety

- Monitoring of the client, e.g.,

. observe for signs of change in the condition
. prompt client to take medications as directed
. basic recognition of medical problems/and medical emergency
. basic first aid for emergencies

- Record keeping, e.g.,

. a daily log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.

. summary prepared weekly by the PCW and reviewed at least once every two weeks by the supervising nurse(s).

- Communication skills

- Basic infection control

b. Proof of the training must be recorded in the personnel file.

c. The DSP will be responsible for providing a minimum of twelve (12) hours relevant in-service training per calendar year (The annual in-service training requirements can be done on a pro-rated basis). Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed four of the twelve in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

6. Personnel files:
Individual records will be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

An individual client record must be maintained by the DSP. The requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PC services within three (3) working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date as stated on the Provider Contract.

2. The DSP will notify the Case Manager within three (3) working days of the following client changes:

a. Client's condition has changed and the Plan of Care no longer meets client's needs or the client no longer appears to need PC services.

b. Client dies or moves out of the service area.

c. Client no longer wishes to participate in a program of PC services.

d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

3. The DSP will maintain a record keeping system which establishes a client profile in support of units of PC service delivered, based on the Service Provider Contract. The DSP will arrange a daily log reflecting the personal care services provided by the PCWs for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or family member/responsible person if the client is unable to sign, and the PCW. In the event the client is not physically able to sign and the family member/responsible person is not present to sign, then the PCW must document the reason the log was not signed by the client or family member/responsible person. The daily log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

4. The DSP must complete the sixty (60) day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (l0) calendar days after the sixty (60) day supervisory review. In the event the client is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC services.

5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the PC services as authorized. Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be reported in writing on Medicaid's 'WEEKLY MISSED VISIT REPORT' form to the case manager on Monday of each week. A missed visit is as follows: When the client is at his/her residence waiting for scheduled services and the services are not delivered. The provider cannot bill for missed visits.

6. Whenever two consecutive attempted visits occur, the case manager must be notified. An attempted visit is when the PCW arrives at the residence and is unable to provide the assigned tasks because the client is not at his/her residence or refuses services. "The provider cannot bill for attempted visits."

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the administering agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.

8. The DSP will inform clients of their right to complain about the quality of PC services provided and will provide clients with information about how to register a complaint. Complaints which are made against PCWs will be assessed for appropriateness and investigation by the DSP. All complaints which are to be investigated will be referred to the Nurse Supervisor who will take appropriate action. The DSP must maintain documentation of all complaints and follow-ups.

9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PC services to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed and the service contract form submitted prior to the provision of PC services. The DSP must maintain documentation showing that it has complied with the requirements of this section.

10. The Case Manager will authorize PC services by designating the amount, frequency and duration of service for clients in accordance with the client's Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identifies PC duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the Case Manager to discuss the possibility of having these duties included in the Plan of Care and the Service Provider Contract. The decision to modify the duties to be performed by the PCW is the responsibility of the Case Manager, and the Plan of Care and the Service Provider Contract must be amended accordingly. This documentation will be maintained in the client records.

11. The Case Manager will review a client's Plan of Care within three (3) working days of receipt of the DSP's request to modify the Plan of Care.

12. The Case Manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating the services. The Case Manager must verify Medicaid eligibility on a monthly basis.

13. Under no circumstance should any type of skilled medical service be performed by a PCW.

14. No payment will be made for services not listed on the Plan of Care and the Service Provider Contract.

15. The DSP will retain a client's file for at least five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The DSP Agency will inform the client/responsible party of their right to complain about the quality of PC services provided and will provide information about how to register a complaint.

   a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

   b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action.

   c. The PCW Supervisor will take any action necessary and document the action taken in the client's and employee's files.

   d. The PCW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

2. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP agency. The DSP agency shall notify the administering agency within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The agency organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. his information shall be readily accessible to all staff. A copy of this information shall be forwarded to the administering agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP agency and to the administering agency.

3. The DSP agency must have written bylaws or equivalents which are defined as "a set of rules adopted by the DSP agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the DSP agency and shall be provided to the administering agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the DSP agency. A listing of the members of the governing body shall be made available to the administering agency upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to the administering agency prior to the signing of the initial contract with the administering agency. The DSP agency must maintain an annual operating budget which shall be made available to the administering agency upon request.

7. The DSP agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP agency shall furnish a copy of the insurance policy to the administering agency.

8. The DSP agency shall ensure that key agency staff, including the agency administrator or the Nurse Supervisor, be present during compliance review audits conducted by Medicaid, the administering agency and/or its agents.

9. The DSP agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)
SAIL WAIVER

Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individuals, or which enables the individuals to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

This service is necessary to prevent the institutionalization of the recipient. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Limits on EAA are $5,000 per waiver client for the entire stay on the waiver. Any expenditure in excess of $5,000 must be approved by the state coordinator and the Medicaid designated personnel. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

A. Objective

The objective of Environmental Accessibility Adaptations Services (EAA) is to ensure the health, welfare and safety of the individuals which enables them to function with greater independence in their current living arrangements.

B. Provider Qualifications

EAA will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor. If the contractor is not licensed, the case manager will ask the Rehabilitation Technology Specialist to do a

final inspection to ensure compatibility with local building code.

C. Description of Services To Be provided

1. The SAIL Waiver program will pay for this service when items requested are not covered under the regular State Plan program and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA medical record on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. The adaptations shall not include any improvements to the home which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc.

3. All services shall be provided in accordance with applicable state or local building codes, and ADAAG regulations. This service will be provided by a licensed contractor.

D. Conduct of Service

1. Environmental Accessibility Adaptations should be ordered and arranged for by the SAIL Waiver case manager. The case manager should consult with a Rehabilitation Technology Specialist (RTS) to assist when there is questionable doubt as to the construction of EAA. RTS may also be utilized in developing specifications and in obtaining final approval of completed modification adaptations.

   The case manager must make sure that all the requirements are met.

2. Environmental Accessibility Adaptations must be prior authorized and approved by the Alabama Medicaid Agency Prior Authorization Unit, and must be listed on the clients' Plan of Care. The maximum amount for this service is $5,000 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of $5,000 must be approved by the state coordinator and the Medicaid designated personnel.

3. A PRESCRIPTION IS NOT REQUIRED FOR THIS SERVICE.

4. Upon completion of the service, the clients must sign and date a form acknowledging receipt of the service. If the client is not pleased with the service, the

contractor is required to make adjustments as long as the complaints are within reason.

MEDICAL SUPPLIES
SAIL WAIVER

Medical supplies includes devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

Medical supplies are necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical Supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

A. Objective:

The objective of the Medical Supplies service is to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. Medical supplies ensure health and safety for the duration of usefulness of supplies. Medical supplies are necessary for the care and functional capabilities of the recipient in the home.

B. Provider Experience

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. The case manager must provide the participant with a choice of vendors in the local area of convenience.

C. Description of Services To Be Provided

1. Medicaid will pay for a service when the service is covered under the SAIL Waiver and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. Medical supplies are necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.

3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.

4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

5. All items shall meet applicable standards of manufacture, design and installation. Supplies are limited to $1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

D. Conduct of Service

1. This service will only be provided when authorized by the recipient's physician.

2. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services.

3. Supplies and medications must be indicated on the recipient's Plan of Care, they must be medically necessary to maintain the recipient's ability to remain in the home
and live independently.

4. Reimbursement for medical supplies shall be limited to $1800.00 annually per recipient. Receipt for all supplies purchased must be kept in the recipient's case record.

5. The case manager must provide the recipient with a choice of vendors in the area. A signed Participant Choice of Vendor form should be placed in the case file and a copy provided to the participant. Services should not be denied due to an absence of the signature of the recipient.

6. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes.

MINOR ASSISTIVE TECHNOLOGY
SAIL WAIVER

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

Minor Assistive Technology is necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition. MAT does not include common over-the-counter personal care items. Items reimbursed with waiver funds shall be in addition to any medical supplies or devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Minor Assistive Technology is limited to $500.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

A. Objective:

The objective of Minor Assistive Technology is to increase the functional capabilities of a participant and to promote safety and prevent further deterioration of participant's medical status. This service is necessary to prevent institutionalization.

B. Provider Experience

Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. Vendors providing MAT/devices should be capable of supplying and training in the use of minor assistive technology/device.

C. Description of Services To Be Provided

1. Medicaid will pay for a service when the service is covered under the SAIL Waiver and is medically necessary. "Medically Necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. MAT/devices include those assistive aids necessary for the recipient to perform or assist in performing activities of daily living skills, and in prevention and

monitoring of medical condition. PA IS NOT REQUIRED FOR THIS SERVICE.

3. MAT authorizations include, but are not limited to: shower chairs, specialized cushions, alternating pressure pad and pump, specialized mattresses, over the bed table, shampoo tray, reachers, lifter sling, transfer board, glucometer, green boots, urinal, ADL cuff-holders, elbow protectors or pads, hand splints, and specialized feeding utensils or additional medical supplies to maintain health and safety. MAT/devices must be prescribed by a physician.

4. Items reimbursed with waiver funds shall be in addition to any MAT/devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

5. MAT/devices are limited to $500.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipient.

A. Conduct of Service

1. This service will only be provided when authorized by the recipient's physician.

2. The case manager must provide the participant with a Participant Choice of Vendor list. The case manager must arrange with the vendor to provide the MAT for the participant.

3. A Participant Choice of Vendor form must be written and signed by the responsible person. The form should be placed in the case file and a copy provided to the participant.

4. If provided, Minor Assistive Technology must be included on the Plan of Care.

5. A prescription for service must be in writing from the physician. Providers must have an agreement with the Department of Rehabilitation Services and should be a provider of the Alabama Medicaid Agency.

6. A delivery ticket signed by the participant is required prior to payment.

ASSISTIVE TECHNOLOGY
SAIL WAIVER

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. All items shall meet applicable standards of manufacture, design and installation.

A. Objective

The objective of Assistive Technology service is to increase, maintain or improve functional
capabilities or individuals with disabilities. It will also help ensure the health and safety for the recipient which enables them to function with greater independence in their current residence.

B. Provider Qualifications

Businesses providing Assistive Technology services will possess a business license. Vendors are responsible for orientation to the equipment.

C. Description of Services To Be Provided

1. The SAIL Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each recipient must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

2. Assistive Technology includes pieces of equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities.

3. The amount for this service is $15,000.00 per waiver recipient. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the Medicaid designated personnel.

4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric). The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

D. Conduct of Service

1. Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology before requesting prior approval.

2. To obtain Prior Authorization numbers for this service, the case manager must submit a copy of the following documents:

   a. Medicaid Prior Authorization Form (#342).

   b. Price quotation list from the company supplying the recipient with equipment and specifying the description.

   c. A copy of the physician's prescription. Copies must be legible.

3. Assistive Technology must be prior authorized and approved by the Alabama Medicaid Agency Prior Authorization Unit and must be listed on the client's Plan of Care. The prior authorization packet is submitted to ADRS by the case manager and ADRS submits prior authorization requests using the Medicaid Prior Authorization Form (342).

   Prior authorization is also required for Transitional Assistive Technology. ADRS will submit the prior authorization request packet to the Alabama Medicaid Agency Long Term Care Project Development/Program Support Unit for review and coordination.

4. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

5. Upon completion of the service, the client must sign and date, acknowledging receipt of the service.

6. The case manager should secure an EOMB (Explanation of Medicare Benefits)

from the vendor if Medicare can be applied towards purchase before the final payment will be processed for Assistive Technology. Explanation of benefits should also be secured if the recipient has other insurance.

EVALUATION FOR ASSISTIVE TECHNOLOGY
SAIL WAIVER

This service will provide for an evaluation and determination of the client's need for Assistive Technology. The evaluation must be physician-prescribed and be provided by a therapist licensed to do business in the State of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

A. OBJECTIVE:

To maintain the recipient's health, safety and welfare through appropriate evaluation of the recipient's need for Assistive Technology. The physical therapist's evaluations will allow only medically necessary equipment/devices to be authorized by the Medicaid Agency. This service is necessary to prevent institutionalization.

The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

B. SCOPE OF SERVICE INCLUDES THE FOLLOWING ELEMENTS:

Complete patient assessments related to various physical skills and functional ability including neuro-muscular, coordination and control, balance and ambulation. Take recommendations regarding appropriate Assistive Technology. Confer with the case manager and referring physician as needed. Maintain record of evaluation

C. PROVIDER QUALIFICATIONS:

Graduate from an accredited Physical Therapy institution
Alabama license in Physical Therapy
Any qualified providers meeting qualifications must be enrolled as a provider with ADRS
No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of Assistive Technology equipment/devices

D. CONDUCT OF SERVICE:

This service must be prescribed by the physician and arranged for by the case manager.

When applicable, a written copy of the physical therapist's evaluation must accompany the prior authorization request and a copy must be kept in the recipient's file.

This service must be listed on the recipient's plan of care before provided.

Reimbursement for this service will be the standard cost per evaluation as determined by Alabama Medicaid and ADRS.

The recipient must be given the choice of qualified enrolled providers for this service.

ASSISTIVE TECHNOLOGY REPAIRS
SAIL WAIVER

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items and services must meet applicable standards of manufacture, design and installation.

A. OBJECTIVE:

To prevent repair delays when it is determined by the case manager that repair(s) are needed to maintain the recipient's health, safety and welfare.

B. PROVIDER STANDARDS:

Business providing these repairs will possess a business license. They will also be required to give a guarantee on work performed.

C. DESCRIPTION OF SERVICE TO BE PROVIDED:

1. The SAIL Program will pay for repairs on equipment previously purchased through the waiver.

2. The provider shall be responsible for replacement or repair of the equipment on any part thereof that is found to be non-functional because of faulty material or workmanship within the guarantee of the manufacturer without any charge to the recipient or the Alabama Department of Rehabilitation Services.

3. Repairs outside the warranty period will be reimbursed by ADRS.

4. The maximum amount for this service is $2,000.00 per recipient annually.

D. CONDUCT OF SERVICE:

1. Repairs must be arranged for by the case manager. It must be documented in the Plan of Care and case narrative. Prior authorization is not required for this service.

2. The case managers must make sure the equipment is not:

   a. Under warranty by manufacturer before using this service.

b. Not covered by any other third party insurance before using this service.

3. A copy of the guarantee should be in the recipient's file.

4. Reimbursement for repairs shall be limited to $2,000.00 annually per recipient. Receipts for all repairs must be kept in the recipient's case record. Repair total must not exceed the amount originally paid for the equipment or device.

E. THIRD PARTY LIABILITY

The provider must make all reasonable efforts to collect from any other health insurance policy a Medicaid recipient may have. Any payment received from the insurance company must be shown on the Medicaid claim when submitted to ADRS. Failure by the provider to collect available third party payments may result in recoupment of these payments by ADRS.

PERSONAL EMERGENCY RESPONSE SYSTEMS (INSTALLATION) SAIL WAIVER

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

A. Objective

The objective of PERS is to assist the recipients who live alone or who are alone for significant parts of the day and do not have a regular caretaker for extended periods of time.

B. Provider Experience

PERS Set-up will be provided by individuals who are trained to install this device for
specific consumers for whom services are being provided.

C. Description of Service Provided

1. The system is connected to a client's phone and programmed to signal a response center once a "help" button is activated.

2. The set-up fee is a one time installation charge. This portion of the PERS service must be prior authorized and approved by the Alabama Medicaid Agency, Prior Authorization Unit.

3. By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

D. Conduct of Services

1. PERS should be ordered and arranged for by the SAIL Waiver case manager.

2. PERS must be prior authorized and approved by the Alabama Medicaid Agency, Waiver Service Unit, and must be listed on the client's Plan of Care. The maximum is a one time installation charge. Once the recipient has had one installation, they cannot get another one approved.

3. Case managers must assure that the Prior Authorization packet contain the following information:

   a. Alabama Review and Authorization Request (PA Form 342).
   b. Approval by the Department of Rehabilitation Services for Vendor Providing the Service
   c. Price Quotation from the Vendor Providing the Service Specifying the Description of Personal Emergency Requested.
   d. A Prescription from the Physician.

5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service. If the client is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

SAIL WAIVER

This service will cover the monthly fee after the system has been installed. The same objective, provider experience, etc., for PERS (S5161-UB) will apply for this service.

PERSONAL ASSISTANCE SERVICE
SAIL WAIVER

PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities. These activities would be performed by the individual if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities.

This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service will be sufficient enough to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in the amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A. OBJECTIVE

The objective of PAS is to provide a range of services designed to assist an individual with physical disabilities to perform activities on and off the job.

B. PROVIDER EXPERIENCE

Agencies desiring to be a provider of PAS must have demonstrated experience in providing PAS or a similar service to the Operating Agency (OA).

C. DESCRIPTION OF SERVICES TO BE PROVIDED

1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to enter or to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.

2. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.

3. The PAS received by an individual will be based on the individual's needs. The number of hours must be stipulated on the Plan of Care and Service Provider Contract.

4. IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE.

5. PAS is required, but are not limited to assisting with:

In Home
Routine bathing and toileting
Dressing and undressing
Preparation and consumption of food
Personal grooming
Getting in and out of bed
Laundry
Bladder and bowel care
Medication Monitoring

Outside Home/Job Site
Shopping
Transportation to and from work
Eating
Toileting
Medication Monitoring
Banking/paying bills
Retrieving work materials that are out of reach
Entering or exiting doors
Distributing materials to different locations of the building when necessary.

D. STAFFING

The Direct Service Provider (DSP) must provide all of the following and may make subcontractual arrangements for some but not all of the following:

1. A registered nurse(s) who meets the following requirements:

a. Currently licensed by the Alabama State Board of Nursing to practice nursing

b. At least two (2) years experience as a registered nurse in public health, hospital or long term care nursing

c. Must pass a statewide and local background check

d. Capable of evaluating the PAS worker in terms of his or her ability to carry out assigned duties and his/her ability to relate to the client

e. Ability to assume responsibility for in-service training for the Personal Care attendants by individual instructions, group meetings or workshops

f. Current verification of an annual TB Skin Test must be in the employee's personnel record.

2. A Personal Care Attendant who meets the following qualifications and requirements:

a. Must have references which can be verified thoroughly and must show no adverse reports on local/statewide background check

b. Must have no physical/mental impairment to prevent lifting transferring, or providing any other assistance to the recipient

c. Must assist recipient appropriately with daily living activities as related to personal care

d. Be at least 21 years of age

e. Driver's license and proof of insurance

f. Must have at least a 10^{th} grade education, preferably, high school graduate or GED

g . Must be free from communicable diseases. Current verification of an annual TB Skin Test must be in the employee's personnel record.

h. Must be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

i. Must be employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

j. Must complete a probationary period determined by the employer with continued employment contingent on completion of a personal care in-service training program and client's satisfaction.

k. Personal Assistant services provided by family members or friends may be covered only if family members or friends meet qualifications for providers of care; there

are strict controls to assure that payment is made to the relatives or friends only in return for Personal Assistance Services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The case manager must have documentation in the client's file showing that attempts were made to secure other qualified providers before a family member or friend is considered. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent. The OA is responsible for reviewing these records and verifying there is proper documentation of lack of qualified providers living in a remote area

l. Personal Choices participants (Cash and Counseling Pilot Project) may hire legally liable relatives, as paid providers of the personal assistance services. However, restrictions do apply on participant living arrangements, when homes or property are

owned, operated or controlled by a provider of services, not related by blood or marriage to the participant. (refer to: AL SPA 07-002; Attachment 3.1-A 1915 (J) vi.)

3. Nursing Supervision:

PAS services must be provided under the supervision of the registered nurse who meets the PAS staffing requirements and will:

a. Make visits to the client's residence after the initial visit by the registered nurse.

b. Be immediately accessible by phone during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours.

c. Provide and document supervision of, training for, and evaluation of PAS workers according to the requirements in the approved waiver document.

d. Provide on-site (clients' place of residence) supervision of the PAS worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances of the PAS worker.

e. Observe each PAS worker with at least one (1) assigned client at a minimum of Every six (6) months or more frequently if warranted by substandard performance of the PAS worker. This function may be carried out in conjunction with one of

the 60-day supervisor visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file.

f. Assist PAS workers as necessary as they provide individual personal care services as outlined by the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

4. The following are the minimum training requirements for PAS workers. The minimum training requirement must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training. Proof of training must be recorded in the personnel file

The PAS training program should stress the physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, his/her workplace and his/her property.

NOTE: The PAS training program must be approved by the OA.

Minimum training requirements must include the following areas:

a. **Monitoring of the client, e.g.,**
. observe for signs of change in the condition
. prompt client to take medications as directed
. basic recognition of medical problems/and medical emergency
. basic first aid for emergencies

b. **Record Keeping, e.g.,**
. a daily log signed by the client or family member/responsible person and PAS Worker to document what services were provided for the client in relation to the Plan of Care and signed at least once every two weeks by the supervising nurse.

c. Basic Infection Control

d. Communication skills

e. The DSP will be responsible for providing a minimum of twelve (12) hours relevant in-service training per calendar year. (The annual in service training requirements can be done on a prorated basis.) Documentation shall include topic, name and title of trainer, training objectives, and outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided

as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed four of the twelve in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

5. Personnel files:
Individual records will be maintained to document that each member of the staff has met the above requirements.

E. Conduct of Service

An individual client record must be maintained by the DSP. The requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PAS within three (3) working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date as stated on the Provider Contract.

2. The DSP will notify the case manager within three (3) working days of the following client changes:

   a. Client's condition has changed and the Plan of Care no longer meets client's needs or the client no longer appears to need PAS.

   b. Client dies or moves out of the service area.

   c. Client no longer wishes to participate in a program of PAS.

   d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

   e. Client becomes unemployed.

3. The DSP will maintain a recordkeeping system which establishes a client profile in support of units of PAS delivered, based on the
Service Provider Contract. The DSP will arrange a daily log reflecting the personal assistance services provided by the PAS worker for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or employer/family member/responsible person if the client is unable to sign, and the PAS worker. In the event the client is not physically able to sign and the employer/family member/responsible person is not present to sign, then the PAS worker must document the reason the log was not signed by the client or employer/family member/responsible

person. The daily log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

4. The DSP must complete the sixty (60) day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the case manager within ten (10) calendar days after the sixty (60) day supervisory review. In the event the client is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of the PAS.

5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives PAS as authorized. Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be reported in writing on Medicaid's 'WEEKLY MISSED VISIT REPORT' form to the case manager on Monday of each week. A missed visit is as follows: When the client is at his/her residence waiting for scheduled services and the services are not delivered. The provider cannot bill for missed visits.

6. Whenever two consecutive attempted visits occur, the case manager must be notified immediately. An attempted visit is when the PAS worker arrives at the residence and is unable to provide the assigned tasks because the client is not at his/her residence or refuses services. "The provider cannot bill for attempted visits."

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the operating agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.

8. The DSP will inform clients of their right to complain about the quality of PAS provided and will provide clients with information about how to register a complaint. Complaints which are made against PAS workers will be assessed for appropriateness and investigated by the DSP. All complaints which are to be investigated will be referred to the Nurse Supervisor who will take appropriate action. The DSP must maintain documentation of all complaints and follow-ups.

9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PAS to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed and the service contract form submitted prior to the provision of PAS. The DSP must maintain documentation showing that it has complied with the requirements of this section.

10. The case manager will authorize PAS by designating the amount, frequency and

duration of service for clients in accordance with the client's Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identified PAS duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the case manager to discuss the possibility of having these duties included in the Plan of Care and the Service Provider Contract. The decision to modify the duties to be performed by the PAS worker is the responsibility of the case manager, and the Plan of Care and the Service Provider Contract must be amended accordingly. This documentation will be maintained in the client records.

11. The case manager will review a client's Plan of Care within three (3) working days of the receipt of the DSP's request to modify the Plan of Care.

12. The case manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating the services. The case manager must verify Medicaid eligibility on a monthly basis.

13. Under no circumstance should any type of skilled medical service be performed by a PAS worker.

14. No payment will be made for services not listed on the Plan of Care and the Service Provider Contract.

15. The DSP will retain a client's file for at least five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The DSP Agency will inform the client/responsible party of their right to complain about the quality of PC services provided and will provide information about how to register a complaint.

   a. Complaints which are made against PAS worker will be investigated by the DSP Agency and documented in the client's file.

   b. All complaints which are to be investigated will be referred to the PAS Supervisor who will take appropriate action.

   c. The PAS Supervisor will take any action necessary and document the action taken in the client's and employee's files.

   d. The PAS Supervisor will contact the case manager by letter or telephone about

any complaint and any corrective action taken.

2. The DSP must maintain documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-service training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP agency. The DSP agency shall notify the operating agency within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The agency organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. This information shall be readily accessible to all staff. A copy of this information shall be forwarded to the operating agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP agency and to the operating agency.

3. The DSP agency must have written bylaws or equivalents which are defined as "a set of rules adopted by the DSP agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the DSP agency and shall be provided to the operating agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the DSP agency. A listing of the members of the governing body shall be made available to the operating agency upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to the operating agency prior to the signing of the initial contract with the administering agency. The DSP agency must maintain an annual operating budget which shall be made available to the operating

agency upon request.

7. The DSP agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP agency shall furnish a copy of the insurance policy to the operating agency.

8. The DSP agency shall ensure that key agency staff, including the agency administrator or the Nurse Supervisor, be present during compliance review audits conducted by Medicaid, the operating agency and/or its agents.

9. The DSP agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1.___ Low income families with children as described in section 1931 of the Social Security Act.

2. X SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under ə 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. X Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal Poverty Level (FPL)

b.___% Percent of FPL which is lower than 100%.

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

___ A. Yes X B. No

Check one:

a.___ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

_____ of FBR, which is lower than 300% (42 CFR 435.236)

$ ___ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR 435.320, 435.322, and 435.324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.___ 100% of the FPL

b._____% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.___ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330.)

8. X Other (Include only statutory reference to reflect additional groups under your plan that you

wish to include under this waiver.)

SSI RELATED PROTECTED GROUPS DEEMED TO BE MEDICAID ELIGIBLE

These groups would include:

1. Continuous – Those individuals who are not eligible for SSI because their income exceeds the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977 ("Pickle People") (42 CFT 435.135).

2. Disabled Adult Child – An Individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child (P.L. 99-643).

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under ə435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (ə435.217). For individuals whose eligibility is not determined under the spousal rules (ə1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR ə435.726 and ə435.735 just as it does for other individuals found eligible under ə435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under ə1924.

REGULAR POST-ELIGIBILITY RULES--ə435.726 and ə435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--ə1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of ə1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The ə1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in ə1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the ə1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

A. **ə 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. X The following standard included under the State plan (check one):

(1) X SSI

(2) ___ Medically needy

(3) X The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___ %

(5) X Other (specify):
Individuals who would be eligible for SSI or optional state supplements as specified in 42 CFR 435.230 - if not in an institution

B. ___ The following dollar amount:
$ _____ *
*If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. Is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deducting the following amounts from the waiver recipients' income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:_____%

(5)___ Other (specify):

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ə435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the Stateэs approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of ə1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under ə1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

_X_ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_X_ Other (Specify):

Rehabilitation Counselor

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_X_ "Tickler" file

___ Edits in computer system

___ Component part of case management

_X_ Other (Specify): Case Managers

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid Agency in its central office

___ By the Medicaid Agency in district/local offices

_X_ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_X_ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

X By service providers

___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 5 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used

for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Copies of Freedom of Choice forms will be on file at the Department of Rehabilitation Services state and area offices.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_X_ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

___ Case Manager

_X_ Other (specify):

____ Rehabilitation Counselor.

2. Copies of written plans of care will be maintained for a minimum period of 5 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid Agency central office

___ At the Medicaid Agency county/regional offices

_X_ By case managers

_X_ By the agency specified in Appendix A

___ By consumers

___ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic

review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (specify):

.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

DATE: October 2007

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency:

The plan of care is included in the original application package. The plan of care must be approved by the Operating Agencies Nurse Consultant. If the plan of care is of such complexity that the Quality Assurance nurses cannot approve, it will be referred to the Medicaid Agency's staff physician.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid Agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

__X__ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

a. When the individual was eligible for Medicaid waiver payment on the date of service;

b. When the service was included in the approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with

Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

____ Yes

__X__ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

__X__ All claims are processed through an approved MMIS.

____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 5 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

__X__ The Medicaid Agency will make payments directly to providers of waiver services.

__X__ The Medicaid Agency will pay providers through the same fiscal agent used in he rest of the Medicaid program.

____ The Medicaid Agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

__X__ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

Waiver claims from these providers will be submitted to the same Medicaid Fiscal Agent used by the rest of the Medicaid programs using unique provider

numbers and service indicators for tracking. Adjudication of these waiver claims will be made by the Medicaid Fiscal Agent used by the rest of the Medicaid programs.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid Agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1

COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted

average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	20,228	5,205	24,327	4,400
2	21,074	5,424	25,348	4,584
3	21,960	5,652	26,413	4,777
4	22,879	5,889	27,522	4,977
5	23,840	6,136	28,678	5,187

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	660
2	660
3	660

4 660

5 660

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

_X_ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: __NF__

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2

FACTOR D
LOC: NF

Demonstration of Factor D estimates:

Waiver Year 1___ 2___ 3___ 4___ 5

DATE: October 2007

Waiver Service Column A	#Unduplicated Recipients (Users) Column B	Avg. # Annual Units Per User Column C	Average Unit Cost Column D	Total Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

GRAND TOTAL (SUM OF COLUMN E):

AVERAGE LENGTH OF STAY:

N/A

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living

arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_X_ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated

live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'
LOC: NF

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)
LOC: NF

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2003-2004 with a 4.2 percent inflation factor applied to each year of the renewal period.

APPENDIX G-6

FACTOR G
LOC: NF

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for years ____of waiver #____, which

reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2003-2004 with a 4.2 percent inflation factor applied to each year of the renewal period.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'
LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would

return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'
LOC: NF

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

Based on data shown by the HCFA-372 Report, Waiver #0241.90.02, for waiver year 2003-2004 with a 4.2 percent inflation factor applied to each year of the renewal period.

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY
LOC: NF

YEAR 1

FACTOR D:	20,228		FACTOR G:	24,327
FACTOR D:	5,205		FACTOR G:	4,400
TOTAL	25,433	<	TOTAL:	28,727

YEAR 2

FACTOR D:	21,074		FACTOR G:	25,348

FACTOR D:	5,424		FACTOR G:	4,584
TOTAL:	26,498	≤	TOTAL:	29,932

YEAR 3

FACTOR D:	21,960		FACTOR G:	26,413
FACTOR D:	5,652		FACTOR G:	4,777
TOTAL:	27,612	≤	TOTAL:	31,190

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)
LOC: NF

YEAR 4

FACTOR D:	22,879		FACTOR G:	27,522
FACTOR D:	5,889		FACTOR G:	4,977
TOTAL:	28,768	≤	TOTAL:	32,499

YEAR 5

FACTOR D:	23,840		FACTOR G:	28,678

FACTOR D:	6,136		FACTOR G:	5,187
TOTAL:	29,976	≤	TOTAL:	33,865